Mental Health Redesign and Implementation Task Force

Milwaukee County Mental Health Complex – Room 1045
Wednesday, October 3, 2012
3:00 – 5:00 p.m.

Members: Barbara Beckert, Beth Burazin, Pete Carlson, Héctor Colón, Kristina Finnel, Rachel Forman, Michelle Gehring (for Scott Gelzer), Peter Hoeffel, Henry Kunath, Jon Lehrmann, Cheryl Lofton, Paula Lucey, Jim Mathy, Mary Neubauer, Tom Nowak, Joy Tapper, Joe Volk, Peggy Romo West, Sally Winkelman (for Larry Pheifer), Nathan Zeiger

Staff/Guests: Pat Bellittiere, Serge Blasberg, E. Marie Broussard, Chris Cline, Pam Fleider, Sue Gadacz, Lois Gildersleeve, David Johnson, Jim Kubicek, Walter Laux, Amy Lorenz, Jodi Mapp, Ken Minkoff, Laura Riggle, Jan Wilberg, Jennifer Wittwer, Tracy Wymelenberg

Welcome and introductions

Héctor Colón and Paula Lucey welcomed attendees and reintroduced the technical assistance team: Jan Wilberg (Wilberg Community Planning) and Ken Minkoff and Chris Cline (ZiaPartners).

Presentation on implementation plan development (slides attached below)

Jan Wilberg gave a presentation outlining a meeting facilitation model for the Action Teams, the recommendations associated with each Action Team, and plans for next steps to work with the Action Teams regularly, starting in October, to develop an implementation framework over the next six months. There was discussion about how the Action Teams would organize the meeting, how the activities would translate into a data-driven plan, and how all the activities related to the big picture. These questions were briefly discussed by the technical assistance consultants.

Discussion

Dr. Lehrmann requested that the Task Force members be kept in the communication loop for all implementation activities. The issue of communication was discussed briefly and was tabled for further discussion about how best to define the role of the Task Force as partners in redesign implementation.

There was general discussion about the importance of all the aspects of redesign coming together so that due recognition is given to the considerable activity that has been already accomplished and to those who have contributed to that work. The group indicated the importance of working in partnership to achieve the redesign goals.

There was discussion the timing of next steps for presenting an implementation plan at an upcoming meeting of the Health and Human Needs Committee. This discussion was deferred to be resolved after the meeting.

Next steps

The Task Force will meet next on **Wednesday, October 31, at 3:00** in Room 1045 of the Mental Health Complex. The following meeting will be **Wednesday, December 5.**

Begin with the end in mind.

Stephen R. Covey, The 7 Habits of Highly Effective People

ACTION PLAN for the Redesign of Mental Health Services in Milwaukee County that:

- **Establishes priorities** for system improvement
- Identifies **specific action steps** required to implement those priorities
- **Assigns responsibilities** to public and private stakeholders
- **Calculates costs** and identifies funding sources
- **Establishes clear accountability** and performance timelines

2

The Task at Hand

- Conduct a focused, intensive process to create a detailed **Action Plan** for mental health redesign implementation that includes:
  - Designation of action steps, timelines, responsible parties, costs, and expected outcomes for each Redesign Action Team recommendation
  - Monthly working meetings October 2012 – March 2013
  - Use of the Drucker Foundation Action Planning Methodology
  - Provision of staff support and technical expertise
  - Multiple opportunities for review and input for consumers, advocates, providers, elected officials, and community partners
  - Formal adoption by the Mental Health Redesign Task Force

3

Drucker Action Planning Methodology

1. Is the goal clear and commonly understood?
2. What strategies could lead to achieving the goal?
3. What are the pros and cons of each option?
4. What is the best course of action?
5. What are the major, concrete steps to take?
6. Who will be responsible for carrying them out?
7. What are the measures of progress and achievement?
8. When should performance be appraised?
9. What human and financial resources are necessary?
10. How will those resources be developed?

4

Implementation Action Teams

- Continuum of Care
- Community Linkages
- Workforce
- Quality Improvement
- Person-Centered Care

5

Each Action Team will...

- Have an initial Scope of Work defined by the recommendations of the Redesign planning phase
- Be expected to modify and adjust the Scope of Work to focus on the highest priorities
- Be provided with an analysis of common themes, progress, and accomplishments as a basis for Scope of Work adjustment
- Have the capacity to change composition by adding new members and to change leadership as needed
- Have dedicated staff to conduct research, organize information, and support AT work
- Have the capability to form time-limited smaller task groups to address specific recommendations
- Be supported by the extensive technical assistance resources of ZiaPartners
- Conclude the six-month Implementation Plan Development with recommendations for further implementation planning where necessary

6

Scope of Work Defined

- The Action Teams will work with the BHD staff to inform the development of RFPs and proposal review criteria, and develop of quality assurance standards consistent with county ordinances and procedures and to avoid any real or perceived conflict of interests.

7

Continuum of Care: Scope of Work

- Support and expand mobile crisis services, collaborating with law enforcement with crisis training.
- Develop and expand alternative crisis services such as the Crisis Resource Center, to enable diversions from unnecessary emergency treatment or hospitalization.
- Increase accessibility and flexibility along the continuum of care, enabling consumers to transition between types and levels of care in response to changing needs.
- Use consumer-directed services and peer support to assist consumers in system navigation and development of individualized recovery plans.
- Expand community-based services including increased availability of counseling and medication options for uninsured and underinsured consumers.
- Expand Evidence-Based Practices consistent with SAMHSA guidance.

8

Continuum of Care: Scope of Work

- Increase the geographic diversity of service locations, ensuring coverage in high-need areas of the community.
- Expand small, community-based, short-term residential options to meet the most challenging behavioral needs of individuals with cognitive disabilities, providing necessary specialized training for support staff.
- Encourage and participate in state-level discussion toward the expansion of community-based rehabilitative services offered through Section 1937 of the Social Security Act.
- Address crisis training for law enforcement and health care personnel through the Crisis Intervention Team and Crisis Intervention Partner Programs.
- Gradually downsize inpatient capacity, provided that adequate community-based supports are in place and patient discharges are carefully planned and monitored.

9

Community Linkages: Scope of Work

- Continue blended management partnership between the Housing Division and developers, landlords, and services providers.
- Continue relationship between County and City to maximize public dollars for construction; collectively forge new strategic partnerships with the private sector to attract additional gap financing dollars.
- Pursue partnerships to produce new housing for individuals with cognitive disabilities enrolled in Family Care.
- Downsize approximately 10% of County's contracted CBRF beds by filling vacant county-contracted beds with Family Care enrollees and increasing access to recovery-oriented housing options.
- Explore a new housing model as a step-down from a CBRF to ensure individuals can live in the least restrictive setting even if not ready or able to live in permanent supportive housing.
- Law enforcement, mobile clinicians, hospital ER's, and all providers who deal with challenging behaviors should consistently seek and evaluate opportunities for diversion from the psychiatric emergency department and inpatient admission.
- Promote employment and access to employment services for individuals with severe and persistent mental illness.

10

Community Linkages: Scope of Work

- Support a data link between BHD and the criminal justice system to facilitate better discharge planning for persons involved in both systems; promote regular cross-training.
- Ensure the availability of a spectrum of community-based services for individuals with cognitive disabilities including crisis intervention, stabilization, respite capacity, and enrollment in Family Care (to support the downsizing of Hilltop).
- Incorporate Certified Peer Specialists into TCM/CSP, Crisis Resource Centers, supportive housing, inpatient units, and throughout community agencies.
- Improve discharge planning from acute inpatient and long term care; establish a clearinghouse of current, accurate, accessible information about behavioral health resources in the community.
- Prioritize benefits counseling for consumers to increase access and ensure maximum revenue to fund services.
- Designate an Intervention Specialist position as a liaison between various public and private entities interacting with individuals with the most complex needs.

11

Workforce: Scope of Work

- Work with private providers to adjust culture and build clinical capacity to treat and support persons with severe psychiatric symptoms and complex psychosocial needs.
- Insure that the workforce is reflective of, and sensitive to, the consumer population.
- Emphasize trauma-informed care as a skill for new hires and a priority in professional development for existing staff.
- Strive to make public sector entities competitive with the private sector to ensure consistently high quality services throughout the system.
- Develop strategies to ensure adequate support of mental health professions.
- Promote psychiatry and psychiatric nursing as a profession.
- Promote a culture of ongoing learning, interdisciplinary fluency, and professional development.
- Conduct training and evaluation on use of motivational and person-centered approaches to promote increased participation in services.
- Establish timely access to interpreters and translators with proficiencies in person-centered care and trauma-informed care; train clinicians on proper use of these services.
- Conduct training and periodic self-assessment on cultural competency, how to identify and respond to diverse cultural, language and service needs.

12

Quality Improvement: Scope of Work

- Develop a Quality Assurance/Improvement Steering Committee to monitor core outcome measures, identify process indicators, and develop a dashboard for reporting system-wide.
- Develop a management information system to collect and report common data elements, using mutually agreed upon data points and a collaboratively designed process to store, share, and act upon data.
- Consider QA/QI performance evaluations in the review of proposals for adult community services and review other models of ongoing monitoring and system review for potential guidance.

13

Person-Centered Care: Scope of Work

- Engage consumers and their families as full collaborative partners whose values and informed choices guide the provision of services and the evolution of the system.
- Expand peer support and consumer-operated services to increase satisfaction, increase participation in services, and facilitate easier navigation between access points and levels of care.
- Incorporate principles of trauma-informed care and person-centered recovery into policies and procedures, hiring and training processes, and service delivery at all levels, including attention to health and substance use issues as well as mental health.
- Expand application of the Comprehensive Continuous Integrated System of Care to create accessible and therapeutic environments.
- Utilize multiple media to provide free and easy access to accurate information about prevention, early signs and symptoms, and the spectrum of available services.
- Convene an entity comprised of consumers, providers and other mental health stakeholders to ensure ongoing adherence to the principles of person-centered care and recovery.
- Determine specific training needs and strategies relative to person-centered care for workforce development.

14

Action Plan Development Timeline

Month	Agenda	Products
October	Review and adjust scope of work to reflect progress to date and emerging needs. Identify data and TA needs. Conduct brief Drucker Methodology training Identify need for additional representation and assign recruitment responsibility.	1. Finalized scope of work 2. List of data/ TA needs 3. Plan to recruit additional representation if needed
November	Translation of recommendations to goals. Identification of alternative strategies to achieve goals (TA / data support) Listing of pros and cons for each strategy. Selection of the best course of action.	1. Goal statements 2. Analysis of options 3. Strategic direction/best course of action
December	Action Plan detail: •Major concrete steps •Responsibilities •Measures of progress and achievement •Performance appraisal timeline •Human and financial resources needed •Source of resources (TA / data support)	1. Completed Action Plan detail for a minimum of 50% of goals

15

Action Plan Development Timeline

Month	Agenda	Products
January	Action Plan detail: •Major concrete steps •Responsibilities •Measures of progress and achievement •Performance appraisal timeline •Human and financial resources needed •Source of resources (TA / data support)	1. Completed Action Plan detail for remainder of goals
February	Consolidation and refinement of AT Action Plan	1. Finalized AT Action Plan submitted to full TF
March	Review and critique of comprehensive Action Plan (compilation of all AT Action Plan prepared by staff)	1. Submission of comprehensive Action Plan to full TF for approval

16

TA Resources/Responsibilities

- ZiaPartners: Mental health system transformation, Comprehensive Continuous Integrated System of Care, clinical expertise in mental health and addiction treatment
- TriWest: Financial and data analysis to support system improvement
- Pathways to Housing: Supportive housing innovation including financing and programming
- Wilberg Community Planning: Meeting facilitation and Action Team staffing
- Milwaukee County BHD: David Johnson and E. Marie Broussard: Technical support and coordination

17

Administrative Staff

- BHD administrative staff will take the affirmative steps required to implement actions as informed by the Action Teams in collaboration and consultation with contract management, corporation counsel and other county resources.
- Other organizational leaders will take responsibility to move items within their organizations consistent with their organizational procedures.

18

Discussion

1. Is the proposed Action Plan development approach responsive and appropriate? How could it be improved?
2. Are the proposed Action Teams and their Scopes of Work appropriate? What should be adjusted or changed?
3. Are there critical omissions in the Scopes of Work? In other words, are there important items that were not addressed by the recommendations from the planning phase?

19